Appendix B: Participant Access and Eligibility

B-1: Specification of the Waiver Target Group(s)

a. Target Group(s). Under the waiver of Section 1902(a)(10)(B) of the Act, the state limits waiver services to one or more groups or subgroups of individuals. Please see the instruction manual for specifics regarding age limits. *In accordance with 42 CFR §441.301(b)(6), select one or more waiver target groups, check each of the subgroups in the selected target group(s) that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Target Group	Included	Target SubGroup	Minimum Age	Maximum Age	
				Maximum Age Limit	No Maximum Age Limit
☒ **Aged or Disabled, or Both - General**					
	☒	**Aged**	65		☒
	☒	**Disabled (Physical)**	18	64	
	☒	**Disabled (Other)**	18	64	
☐ **Aged or Disabled, or Both - Specific Recognized Subgroups**					
	☐	**Brain Injury**			☐
	☐	**HIV/AIDS**			☐
	☐	**Medically Fragile**			☐
	☐	**Technology Dependent**			☐
☐ **Intellectual Disability or Developmental Disability, or Both**					
	☐	**Autism**			☐
	☐	**Developmental Disability**			☐
	☐	**Intellectual Disability**			☐
☐ **Mental Illness**					
	☐	**Mental Illness**			☐
	☐	**Serious Emotional Disturbance**			

b. Additional Criteria. The state further specifies its target group(s) as follows:

Additional criteria:
1. Meets NFLOC and is currently residing at a state mental hospital or the psychiatric unit of a hospital, or has a history of failed placements or denials of appropriate placements, or is imminently in danger of losing a current placement due to problematic behaviors; and
2. Has been assessed as medically and psychiatrically stable; and
3. Has a history of frequent or protracted psychiatric hospitalizations, or a history of an inability to remain medically or behaviorally stable for more than six months and within the last year has exhibited behaviors such as self-endangerment, aggression, intrusiveness, intractable psychiatric symptoms, problematic medication management, sexual inappropriateness, or elopement; and
4. Due to the protracted nature of behavior and clinical complexity, has no other placement options as evidenced by having been unsuccessful in finding community placement by otherwise qualified community providers; and
5. Has behavioral or clinical complexity that requires the level of supplementary or specialized staffing available only in the qualified community settings provided through this waiver; and
6. Requires caregiving staff with specific training in providing personal care, supervision and behavioral supports to adults with challenging behaviors.

Absent the waiver, the alternative institution where the individual would receive needed services would be a NF.

c. Transition of Individuals Affected by Maximum Age Limitation. When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one):*

- ○ **Not applicable. There is no maximum age limit**
- ◉ **The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit.**

Specify:

There is no maximum age limit. Persons with disabilities may continue to participate in the waiver beyond the age of 64 as specified in the above chart. A bug in the web based application will not allow the submission of the waiver if this section is left blank.

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (1 of 2)

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*. Please note that a state may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

- ◉ **No Cost Limit.** The state does not apply an individual cost limit. *Do not complete Item B-2-b or item B-2-c*.
- ○ **Cost Limit in Excess of Institutional Costs.** The state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the state. *Complete Items B-2-b and B-2-c*.

  The limit specified by the state is *(select one)*

  - ○ **A level higher than 100% of the institutional average.**

    Specify the percentage:

  - ○ **Other**

    Specify:

- ○ **Institutional Cost Limit.** Pursuant to 42 CFR 441.301(a)(3), the state refuses entrance to the waiver to any otherwise eligible individual when the state reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c.*
- ○ **Cost Limit Lower Than Institutional Costs.** The state refuses entrance to the waiver to any otherwise qualified individual when the state reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the state that is less than the cost of a level of care specified for the waiver.

  Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.

The cost limit specified by the state is *(select one)*:

- ○ **The following dollar amount:**

  Specify dollar amount:

  The dollar amount *(select one)*

  - ○ **Is adjusted each year that the waiver is in effect by applying the following formula:**

    Specify the formula:

  - ○ **May be adjusted during the period the waiver is in effect. The state will submit a waiver amendment to CMS to adjust the dollar amount.**

- ○ **The following percentage that is less than 100% of the institutional average:**

  Specify percent:

- ○ **Other:**

  Specify:

Appendix B: Participant Access and Eligibility

B-2: Individual Cost Limit (2 of 2)

Answers provided in Appendix B-2-a indicate that you do not need to complete this section.

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

c. Participant Safeguards. When the state specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the state has established the following safeguards to avoid an adverse impact on the participant *(check each that applies)*:

- ☐ **The participant is referred to another waiver that can accommodate the individual's needs.**
- ☐ **Additional services in excess of the individual cost limit may be authorized.**

  Specify the procedures for authorizing additional services, including the amount that may be authorized:

☐ **Other safeguard(s)**

Specify:

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (1 of 4)

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The state will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a

Waiver Year	Unduplicated Number of Participants
Year 1	2750
Year 2	3025
Year 3	3328
Year 4	3660
Year 5	4026

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the state may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the state limits the number of participants in this way: *(select one)* :

◉ **The state does not limit the number of participants that it serves at any point in time during a waiver year.**

○ **The state limits the number of participants that it serves at any point in time during a waiver year.**

The limit that applies to each year of the waiver period is specified in the following table:

Table: B-3-b

Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4	
Year 5	

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

c. Reserved Waiver Capacity. The state may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

○ **Not applicable. The state does not reserve capacity.**

◉ **The state reserves capacity for the following purpose(s).**

Purpose(s) the state reserves capacity for:

Purposes
Reserve capacity for the community transition of institutionalized individuals

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (2 of 4)

Purpose *(provide a title or short description to use for lookup):*

Reserve capacity for the community transition of institutionalized individuals

Purpose *(describe):*

42 waiver slots are reserved for the community transition of individuals institutionalized in a state mental hospital past the time they are determined to be ready for discharge to the community.

Describe how the amount of reserved capacity was determined:

Reserved capacity was determined by the number of potential institutionalized participants in State Mental Hospitals who have the specific service needs that will be met under this waiver.

The capacity that the State reserves in each waiver year is specified in the following table:

Waiver Year	Capacity Reserved
Year 1	42
Year 2	42
Year 3	42
Year 4	42
Year 5	42

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served (3 of 4)

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the state may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one)*:

◉ **The waiver is not subject to a phase-in or a phase-out schedule.**

○ **The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an intra-year limitation on the number of participants who are served in the waiver.**

e. Allocation of Waiver Capacity.

Select one:

◉ **Waiver capacity is allocated/managed on a statewide basis.**

○ **Waiver capacity is allocated to local/regional non-state entities.**

Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Each waiver year, slots will be filled as eligible participants choose to enroll in the waiver.

An individual may self refer or be referred by the treatment team with the person's consent. The individual is then assessed for functional and financial eligibility. If a waiver slot is not available, the applicant will be placed on a waiting list based on the date eligibility was determined.

Once the maximum number of unduplicated participants is reached in each waiver year, no additional participants will be enrolled and a waiting list will be developed. At the beginning of each new waiver year in which there is unused waiver capacity, participants will be prioritized for enrollment, based on the following criteria:
1. Length of time since the participant requested placement;
2. Continued functional and financial eligibility;
3. Geographical preferences; and
4. Choice of provider, setting, and roommate.

If an applicant declines to take a waiver slot due to the geographic location or for any other reason, the individual will remain on the waiting list if he/she still desires a community residential placement. If the individual wants to remain on the waiting list, he/she will retain current placement on the waiting list.

Appendix B: Participant Access and Eligibility

B-3: Number of Individuals Served - Attachment #1 (4 of 4)

Answers provided in Appendix B-3-d indicate that you do not need to complete this section.

Appendix B: Participant Access and Eligibility

B-4: Eligibility Groups Served in the Waiver

a. 1. State Classification. The state is a *(select one)*:

◉ **§1634 State**

○ **SSI Criteria State**

○ **209(b) State**

2. Miller Trust State.
Indicate whether the state is a Miller Trust State *(select one)*:

- (●) **No**
- ( ) **Yes**

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the state plan. The state applies all applicable federal financial participation limits under the plan. *Check all that apply*:

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)

- [ ] **Low income families with children as provided in §1931 of the Act**
- [x] **SSI recipients**
- [ ] **Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121**
- [ ] **Optional state supplement recipients**
- [ ] **Optional categorically needy aged and/or disabled individuals who have income at:**

  Select one:

  - ( ) **100% of the Federal poverty level (FPL)**
  - ( ) **% of FPL, which is lower than 100% of FPL.**

    Specify percentage: [ ]

- [x] **Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)**
- [x] **Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)**
- [ ] **Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)**
- [ ] **Medically needy in 209(b) States (42 CFR §435.330)**
- [ ] **Medically needy in 1634 States and SSI Criteria States (42 CFR §435.320, §435.322 and §435.324)**
- [ ] **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

  Specify:

Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*

- ( ) **No. The state does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.** *Appendix B-5 is not submitted.*
- (●) **Yes. The state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217.**

  Select one and complete Appendix B-5.

○ **All individuals in the special home and community-based waiver group under 42 CFR §435.217**

◉ **Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217**

Check each that applies:

☒ **A special income level equal to:**

Select one:

◉ **300% of the SSI Federal Benefit Rate (FBR)**

○ **A percentage of FBR, which is lower than 300% (42 CFR §435.236)**

Specify percentage:

○ **A dollar amount which is lower than 300%.**

Specify dollar amount:

☐ **Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)**

☐ **Medically needy without spend down in states which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)**

☐ **Medically needy without spend down in 209(b) States (42 CFR §435.330)**

☐ **Aged and disabled individuals who have income at:**

Select one:

○ **100% of FPL**

○ **% of FPL, which is lower than 100%.**

Specify percentage amount:

☒ **Other specified groups (include only statutory/regulatory reference to reflect the additional groups in the state plan that may receive services under this waiver)**

Specify:

Medically Needy with spend down consisting of the state's average monthly cost for Medicaid recipients in nursing facilities determined by multiplying the average daily Medicaid rate by 31. The Medicaid rate is adjusted every July and the state will update the standard in October to allow time to program this parameter in our eligibility system and to synch up with the private rate adjustment used for transfer of assets penalties. Occasional small adjustments in the Medicaid rate may occur at other times but these cannot be predicted. The rate used for eligibility will always be equal to or very close to our actual cost.

This standard will be used to reduce an individual's income to or below the medically needy income standard.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (1 of 7)

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the state furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility

for the special home and community-based waiver group under 42 CFR §435.217:

Note: For the period beginning January 1, 2014 and extending through September 30, 2019 (or other date as required by law), the following instructions are mandatory. The following box should be checked for all waivers that furnish waiver services to the 42 CFR §435.217 group effective at any point during this time period.

☒ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the state uses *spousal* post-eligibility rules under §1924 of the Act.**
Complete Items B-5-e (if the selection for B-4-a-i is SSI State or §1634) or B-5-f (if the selection for B-4-a-i is 209b State) and Item B-5-g unless the state indicates that it also uses spousal post-eligibility rules for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law).

Note: The following selections apply for the time periods before January 1, 2014 or after September 30, 2019 (or other date as required by law) (select one).

◉ **Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group.**

In the case of a participant with a community spouse, the state elects to (*select one*):

◉ **Use spousal post-eligibility rules under §1924 of the Act.**
(Complete Item B-5-b (SSI State) and Item B-5-d)

○ **Use regular post-eligibility rules under 42 CFR §435.726 (SSI State) or under §435.735 (209b State)**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

○ **Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The state uses regular post-eligibility rules for individuals with a community spouse.**
(Complete Item B-5-b (SSI State). Do not complete Item B-5-d)

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (2 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

b. Regular Post-Eligibility Treatment of Income: SSI State.

The state uses the post-eligibility rules at 42 CFR 435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○ **The following standard included under the state plan**

Select one:

○ **SSI standard**
○ **Optional state supplement standard**
○ **Medically needy income standard**
○ **The special income level for institutionalized persons**

(*select one*):

○ **300% of the SSI Federal Benefit Rate (FBR)**
○ **A percentage of the FBR, which is less than 300%**

Specify the percentage: [ ]

○ **A dollar amount which is less than 300%.**

Specify dollar amount:

○ **A percentage of the Federal poverty level**

Specify percentage:

○ **Other standard included under the state Plan**

Specify:

○ **The following dollar amount**

Specify dollar amount: If this amount changes, this item will be revised.

◉ **The following formula is used to determine the needs allowance:**

Specify:

The total personal needs allowance will not exceed 300% of the federal benefit rate, and is the total of:
100% of the federal benefits rate;
Any payee and/or court-ordered guardianship fees;
Any court-ordered guardianship-related costs; plus
An amount for employed individuals equal to the first $65 of the recipient's earned income, plus one-half of any remaining earned income

○ **Other**

Specify:

ii. Allowance for the spouse only (*select one*):

◉ **Not Applicable**

○ **The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:**

Specify:

Specify the amount of the allowance (*select one*):

○ **SSI standard**

○ **Optional state supplement standard**

○ **Medically needy income standard**

○ **The following dollar amount:**

Specify dollar amount: If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

iii. Allowance for the family (*select one*):

○ **Not Applicable (see instructions)**
○ **AFDC need standard**
◉ **Medically needy income standard**
○ **The following dollar amount:**

Specify dollar amount: The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the state's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.

○ **The amount is determined using the following formula:**

Specify:

○ **Other**

Specify:

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

○ **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
○ **The state does not establish reasonable limits.**
◉ **The state establishes the following reasonable limits**

Specify:

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty is limited to zero.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (3 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

c. Regular Post-Eligibility Treatment of Income: 209(B) State.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (4 of 7)

Note: The following selections apply for the time periods before January 1, 2014 or after December 31, 2018.

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant

(*select one*):

- ○ **SSI standard**
- ○ **Optional state supplement standard**
- ○ **Medically needy income standard**
- ○ **The special income level for institutionalized persons**
- ○ **A percentage of the Federal poverty level**

  Specify percentage:
- ○ **The following dollar amount:**

  Specify dollar amount: If this amount changes, this item will be revised
- ◉ **The following formula is used to determine the needs allowance:**

  Specify formula:

  The total personal needs allowance will not exceed 300% of the federal benefit rate, and is the total of:
  100% of the federal benefits rate;
  Any payee and/or court-ordered guardianship fees;
  Any court-ordered guardianship-related costs; plus
  An amount for employed individuals equal to the first $65 of the recipient's earned income, plus one-half of any remaining earned income
- ○ **Other**

  Specify:

ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community.

Select one:

- (●) **Allowance is the same**
- ( ) **Allowance is different.**

Explanation of difference:

iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges
b. Necessary medical or remedial care expenses recognized under state law but not covered under the state's Medicaid plan, subject to reasonable limits that the state may establish on the amounts of these expenses.

Select one:

- ( ) **Not Applicable (see instructions)***Note: If the state protects the maximum amount for the waiver participant, not applicable must be selected.*
- ( ) **The state does not establish reasonable limits.**
- (●) **The state uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.**

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (5 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

e. Regular Post-Eligibility Treatment of Income: §1634 State - 2014 through 2018.

Answers provided in Appendix B-5-a indicate the selections in B-5-b also apply to B-5-e.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (6 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

f. Regular Post-Eligibility Treatment of Income: 209(B) State - 2014 through 2018.

Answers provided in Appendix B-4 indicate that you do not need to complete this section and therefore this section is not visible.

Appendix B: Participant Access and Eligibility

B-5: Post-Eligibility Treatment of Income (7 of 7)

Note: The following selections apply for the five-year period beginning January 1, 2014.

g. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules - 2014 through 2018.

The state uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the state Medicaid Plan. The state must also protect amounts for incurred expenses for medical or remedial care (as specified below).

Answers provided in Appendix B-5-a indicate the selections in B-5-d also apply to B-5-g.

Appendix B: Participant Access and Eligibility

B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the state provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the state's policies concerning the reasonable indication of the need for services:

i. Minimum number of services.

The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is: 1

ii. Frequency of services. The state requires (select one):

- (●) **The provision of waiver services at least monthly**
- ( ) **Monthly monitoring of the individual when services are furnished on a less than monthly basis**

If the state also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

- ( ) **Directly by the Medicaid agency**
- ( ) **By the operating agency specified in Appendix A**
- ( ) **By a government agency under contract with the Medicaid agency.**

Specify the entity:

- (●) **Other**

Specify:

Evaluations and re-evaluations of participant level of care are performed by the local offices of the operating agency.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

In addition to meeting the following minimum qualifications, agency staff must pass a background check prior to being hired and receive mandatory training prior to completing any evaluations.

Initial evaluations are performed by case managers who can be a Registered Nurse (licensed in the State) or a Social Service Specialist. For Social Service Specialists, minimum qualifications are as follows:

A Master's degree in social services, human services, behavioral sciences, or an allied field and two years of paid social service experience equivalent to a Social Service Specialist 2.

OR

A Bachelor's degree in social services, human services, behavioral sciences, or an allied field, and three years of paid social service experience performing functions equivalent to a Social Service Specialist 2.

NOTE: A two year Master's degree in one of the above fields that included a practicum will be substituted for one year of paid social service experience.

NOTE: Employees must successfully complete the formal training course sponsored by their division within one year of their appointment.

NOTE: Equivalent social service experience would include the previous classes of Caseworker 3 or higher.

OR

For Promotion Only: A Bachelor's degree and three years of experience as a Caseworker 3, Social Worker 1A or B, Social Worker 2, Casework Supervisor Trainee, Casework Supervisor, Juvenile Rehabilitation Supervisor 1 or 2, or Juvenile Rehabilitation Counselor 2 in State service.

Job classification descriptions are available from the operating agency.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the state's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool is fully specified in WAC 388-106-0355 (eligibility for nursing facility care services).

Nursing Facility Level of Care (NFLOC) is based on the following factors:
1. The Comprehensive Assessment Reporting Evaluation (CARE) tool is the assessment tool used to determine NFLOC. Functional criteria for NFLOC mean one of the following applies:
a. Care is required to be provided by or under the supervision of a registered nurse or a licensed practical nurse on a daily basis; or

b. The individual has an unmet or partially met need with at least three of the following activities of daily living. For each ADL a minimum level of assistance is required in self performance and/or support provided (self performance and support provided is defined below).

The minimum level of assistance required for each ADL is:
-Eating: Support provided is setup; or
-Toileting and bathing: Self performance is supervision; or
-Transfer, bed mobility, and ambulation: Self performance is supervision and support provided is setup; or
-Medication management: Self performance is assistance required; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

c. The individual has an unmet or partially met need with at least two of the following activities of daily living:

The minimum level of assistance required for each ADL is:
-Eating: Self performance is supervision and support provided is one person physical assist; or
-Toileting: Self performance is extensive assistance and support provided is one person physical assist; or
-Bathing: Self performance is limited assistance and support provided is one person physical assist; or
-Transfer and mobility: Self performance is extensive assistance and support provided is one person physical assist; or
-Bed mobility: includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
-Medication management: Assistance required daily in self performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility; or

d. The individual has a cognitive impairment and requires supervision due to one or more of the following: Disorientation, memory impairment, impaired decision making, or wandering and have an unmet or partially met need with at least one or more of the following:

The minimum level of assistance required for each ADL is:
-Eating: Self performance is supervision and support provided is one person physical assist; or
-Toileting: Self performance is extensive assistance and support provided is one person physical assist; or
-Bathing: Self performance is limited assistance and support provided is one person physical assist; or
-Transfer and mobility: Self performance is extensive assistance and support provided is one person physical assist; or
-Bed mobility: includes limited assistance in self performance and the need for turning and repositioning; and support provided is one person physical assist;
-Medication management: Assistance required daily in self performance; or
-If the need for assistance in any activities listed in this section did not occur because the individual was unable or no provider was available to assist, that need is counted for the purpose in determining functional eligibility.

"Self performance for ADLs" means what the individual actually did in the last seven days before the assessment, not what he/she might be capable of doing. Coding is based on the level of performance that occurred three or more times in the seven-day period and does not include support provided. Self-performance definitions and assessments are consistent with that used under the Minimum Data Set (MDS). This provides a common set of clinical data across all long-term care settings. Self performance level is scored as:

(a) Independent if the individual received no help or oversight, or if the individual needed help or oversight only once or

twice;

(b) Supervision if the individual received oversight (monitoring or standby), encouragement, or cueing three or more times;

(c) Limited assistance if the individual was highly involved in the activity and given physical help in guided maneuvering of limbs or other non-weight bearing assistance on three or more occasions. For bathing, limited assistance means physical help is limited to transfer only;

(d) Extensive assistance if the individual performed part of the activity, but on three or more occasions, the individual needed weight bearing support or the individual received full performance of the activity during part, but not all, of the activity. For bathing, extensive assistance means the individual needed physical help with part of the activity (other than transfer);

(e) Total dependence if the individual received full caregiver performance of the activity and all subtasks during the entire seven-day period from others. Total dependence means complete nonparticipation by the individual in all aspects of the ADL; or

(f) Activity did not occur if the individual or others did not perform an ADL over the last seven days before the individual's assessment. The activity may not have occurred because:

(i) The individual was not able (e.g., walking, if paralyzed);

(ii) No provider was available to assist; or

(iii) The individual declined assistance with the task.

"Support provided" means the highest level of support provided to the individual by others in the last seven days before the assessment, even if that level of support occurred only once.

(a) No set-up or physical help provided by others;

(b) Set-up help only provided, which is the type of help characterized by providing the individual with articles, devices, or preparation necessary for greater self performance of the activity. (For example, set-up help includes but is not limited to giving or holding out an item or cutting food);

(c) One-person physical assist provided;

(d) Two- or more person physical assist provided; or

(e) Activity did not occur during entire seven-day period.

Washington uses an automated assessment system called the Comprehensive Assessment Reporting Evaluation (CARE) tool to evaluate and reevaluate level of care criteria required by the waiver. The CARE tool is available to CMS upon request through the Medicaid agency.

The functions, elements and scoring mechanisms of CARE are spelled out in the Washington State Administrative Code (WAC) 388-106-0050 through 0145.

These WAC references are available to CMS upon request.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

- ◉ **The same instrument is used in determining the level of care for the waiver and for institutional care under the state Plan.**
- ○ **A different instrument is used to determine the level of care for the waiver than for institutional care under the state plan.**

Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation: Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Case managers complete Level of Care evaluations using the automated assessment tool CARE. CARE is used for both initial evaluations and re-evaluations. The re-evaluation process does not differ from the initial evaluation process. Evaluations are completed when an applicant initially applies for long term services and support, annually, and less than annually when a significant change in the participant's condition occurs within the annual plan period. Information about the person's ability to perform Activities of Daily Living and Instrumental Activities of Daily Living, as well as their strengths and preferences is obtained via a face-to-face interview. Evaluators also obtain and verify information by collateral contacts with formal and informal supports including physicians, caregivers, and family.

The timelines to complete each type of assessment is as follows:
- Initial assessments will be completed within 45 days of intake
- Annual and significant change assessments will be completed within 30 days of the assessment creation date

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

- ○ **Every three months**
- ○ **Every six months**
- ○ **Every twelve months**
- ◉ **Other schedule**

Specify the other schedule:

Reevaluations must be conducted every twelve (12) months or whenever there is a significant change in the participant's condition.

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

- ◉ **The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.**
- ○ **The qualifications are different.**

Specify the qualifications:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the state employs to ensure timely reevaluations of level of care *(specify):*

The ProviderOne payment system produces a report for each case manager that lists each service authorization that is expiring or about to expire. Case managers use this information to assure the timeliness of annual reviews in addition to tickler reports produced by CARE. Payment reports are available to identify authorizations that are nearing expiration.

HCS supervisors have a required schedule of record reviews for individual case managers and are responsible for evaluating staff on assessment timeliness. In addition, supervisors use reports produced by CARE to track timeliness of assessments. CARE reports are reviewed on a monthly basis.

Quality assurance staff monitoring of records includes monitoring for timeliness.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the state assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §92.42. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Electronically retrievable documentation of all evaluations and reevaluations is maintained by ALTSA for a minimum of three years at the state level.

Appendix B: Evaluation/Reevaluation of Level of Care

Quality Improvement: Level of Care

As a distinct component of the States quality improvement strategy, provide information in the following fields to detail the States methods for discovery and remediation.

a. Methods for Discovery: Level of Care Assurance/Sub-assurances

The state demonstrates that it implements the processes and instrument(s) specified in its approved waiver for evaluating/reevaluating an applicant's/waiver participant's level of care consistent with level of care provided in a hospital, NF or ICF/IID.

i. Sub-Assurances:

a. ***Sub-assurance: An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
Percent of initial applications with documentation that an assessment was submitted and reviewed for a level of care determination. N=Number of applications received that were submitted and reviewed for a level of care assessment D=Number of applications received

Data Source (Select one):
Analyzed collected data (including surveys, focus group, interviews, etc)
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☒ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☐ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☐ **Representative Sample** Confidence Interval =
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

b. ***Sub-assurance: The levels of care of enrolled participants are reevaluated at least annually or as specified in the approved waiver.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

c. ***Sub-assurance: The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.***

Performance Measures

For each performance measure the State will use to assess compliance with the statutory assurance (or sub-assurance), complete the following. Where possible, include numerator/denominator.

For each performance measure, provide information on the aggregated data that will enable the State to analyze and assess progress toward the performance measure. In this section provide information on the method by which each source of data is analyzed statistically/deductively or inductively, how themes are identified or conclusions drawn, and how recommendations are formulated, where appropriate.

Performance Measure:
The number and percent of participants whose eligibility was determined using the appropriate processes and instruments according to the approved description to determine participant level of care; N = All participants reviewed who received an elibility determination using the appropriate processes and instruments; D = All participants records reviewed who had an eligibility determination.

Data Source (Select one):
Record reviews, off-site
If 'Other' is selected, specify:

Responsible Party for data collection/generation *(check each that applies):*	**Frequency of data collection/generation** *(check each that applies):*	**Sampling Approach** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**	☐ **100% Review**
☒ **Operating Agency**	☐ **Monthly**	☒ **Less than 100% Review**
☐ **Sub-State Entity**	☐ **Quarterly**	☒ **Representative Sample** Confidence Interval = 5%
☐ **Other** Specify:	☒ **Annually**	☐ **Stratified** Describe Group:
	☐ **Continuously and Ongoing**	☐ **Other** Specify:
	☐ **Other** Specify:	

Data Aggregation and Analysis:

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**

Responsible Party for data aggregation and analysis *(check each that applies):*	**Frequency of data aggregation and analysis***(check each that applies):*
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

ii. If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

The CARE assessment as specified in the waiver is the only assessment tool used to determine LOC. To determine LOC, case managers use CARE which is a standardized assessment tool based on the MDS. QA staff and supervisors/managers monitor for appropriate application of the CARE instrument and processes to meet sub-assurance c. (The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.)

Social service supervisors/managers annually monitor worker assessments to ensure LOC accuracy and that a LOC is determined annually or at significant change (approximately 2500 reviews statewide). For new staff, supervisors review the first five assessments. After the first five assessments, a minimum of 50% of LOCs are reviewed for the next three months of employment. After three months, additional reviews are completed at the supervisor's discretion based upon performance. Errors in assessment that can lead to an inaccurate LOC determination are corrected. ALTSA QA unit monitors LOC using a statistically valid sample of records statewide on a 12-month review cycle.

Monitoring activities and data provide evidence of use of the CARE application. LOC determinations that are not correctly determined are corrected and correction is verified at second review. Training to address use of the CARE application is developed based on the data: individual, unit, regional or statewide. CARE enforces rules of eligibility. An algorithm in CARE determines LOC based on information entered into the assessment by the participant and case manager. A LOC determination is completed on all applicants for whom there is reasonable indication that services may be needed in the future. If the participant is not eligible for waiver services, the option is not available for the case manager to select/participant to choose and will not print on the service summary (plan of care).
-An intake is completed at the state agency (HCS) within two working days of receiving the request/referral for services; referrals are entered within one working day for applicants discharging from the hospital.
- The case is assigned to a social worker (the primary case manager) within one working day of the intake date.
- A face-to-face contact is made within two working days of receipt of the referral for applicants coming home from the hospital.
- The initial assessment process timeline is 45 days. The assessment must be completed and services authorized (if eligible) within 45 days from the intake date. Annual and significant change assessments must be completed within 30 days of the assessment creation date.

b. Methods for Remediation/Fixing Individual Problems

i. Describe the States method for addressing individual problems as they are discovered. Include information regarding responsible parties and GENERAL methods for problem correction. In addition, provide information on the methods used by the state to document these items.

Upon completion of each record review, the case manager is expected to make necessary corrections to individual problems. Problems related to health and safety, provider qualifications and payment require either immediate action or must be completed within 3 working days. If the remediation steps are numerous and cannot be completed within 3 working days, they must be initiated for completion within 3 working days. Individual corrections are verified by either the QA unit or the case management supervisor. The QA unit verifies that required corrections have been made at the individual level within 30 days of the preliminary review and documents the verification in the QA monitoring application. Any items that are not corrected within 30 days are followed up by the QA unit to confirm that they have been corrected at 60 days. If items are not corrected by the 60th day, the QA unit follows up with the region until the items are corrected and reports the date of correction to the HCS management team. Supervisors verify that corrections have been made at the individual level prior to completing the review and also document this activity in the QA monitoring application.

Quality assurance proficiency and follow-up reports document prompt assessment and eligibility determinations, accuracy, and remediation. QA reports may be generated at any time and are reviewed on an ongoing basis at all levels of the system. Corrections are made at 30 days and 60 days as identified.

CARE and payment reports are reviewed and corrective action is taken on a monthly basis by supervisors and field managers. Quality assurance proficiency and follow-up reports document prompt assessment and eligibility determinations, accuracy, and remediation.
Case managers are required to take action within 30 days to address all inappropriate LOC determinations identified during the supervisory and QA unit monitoring. CARE management reports include data elements such as: intake date, first assigned date, primary case manager, date assessment created, date moved from pending to current (make payment), setting and transfer dates.

Quality assurance reports and aggregate data are reviewed throughout the year (based on the QA review cycle schedule) by individuals who make decisions on what improvements are needed individually or systemically. Regions are required to develop and submit to the QA unit a Proficiency Improvement Plan (PIP) within 30 days of receiving their final report. The PIP addresses any area where the required proficiency is not met. Plans are reviewed by ALTSA prior to approval and implementation. Progress reporting is unique to each item within the PIP and unique to each region. The region completes a PIP progress report and sends to the QA lead when due with a copy to the QA manager. If the progress report is not received on time, the QA lead follows up with the region. The PIP must be completed by the due date specified on the approved PIP. The HCS management team is notified if a PIP is not completed by the approved due date.

ii. Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*
☐ **State Medicaid Agency**	☐ **Weekly**
☒ **Operating Agency**	☐ **Monthly**
☐ **Sub-State Entity**	☐ **Quarterly**
☐ **Other** Specify:	☒ **Annually**
	☐ **Continuously and Ongoing**
	☐ **Other** Specify:

Responsible Party*(check each that applies):*	**Frequency of data aggregation and analysis** *(check each that applies):*

c. Timelines

When the State does not have all elements of the Quality Improvement Strategy in place, provide timelines to design methods for discovery and remediation related to the assurance of Level of Care that are currently non-operational.

- (●) **No**
- ( ) **Yes**

Please provide a detailed strategy for assuring Level of Care, the specific timeline for implementing identified strategies, and the parties responsible for its operation.

Appendix B: Participant Access and Eligibility

B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the state's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The Department uses a form called Acknowledgement of Services (DSHS 14-225) to document the applicant/participant's freedom to choose between institutional and home and community-based services. The DSHS 14-225 is explained to the individual by the case manager or social worker and a signature is obtained stating that the individual understands they have a choice in the type of services received, where the service is provided as well as the right to a fair hearing. The individual signs this form to designate the service choice.

Fair hearing information is contained on the DSHS 14-225, Acknowledgement of Services form. Rights to a fair hearing are explained to all clients during the Medicaid application process and again during the assessment process.

The client receives a copy of the DSHS 14-225 and a signed copy of the form is maintained in the applicant/recipient's case record.

b. Maintenance of Forms. Per 45 CFR §92.42, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Electronically retrievable copies of forms are maintained by ALTSA for a minimum of three years in the client record at the state level.

Appendix B: Participant Access and Eligibility

B-8: Access to Services by Limited English Proficiency Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the state uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting

Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

Individuals with limited communication access due to disabilities or English proficiency will have access to a variety of services and supports to meet individual service delivery needs and assistance for fair hearing related activities. LEP services and supports include agency or contracted interpreters, bilingual case managers, and translation of written materials.

The following references govern access to services for Limited English Proficient Persons:

-RCW 74.04.025 Bilingual services for non-English speaking applicants and recipients -- Bilingual personnel, when -- Primary language pamphlets and written materials.

-WAC 388-03 Rules and regulations for the certification of DSHS spoken language interpreters and translators.

-WAC 388-271 Limited English proficient services.

-DSHS Administrative Policies

7.20 Communication Access for Persons Who are Deaf, Deaf/Blind and Hard of Hearing
7.21 Access to Services for Clients who are Limited English Proficient (LEP)

The Department of Social and Health Services and its contractors are required by statute, administrative code and department policy to deliver services that recognize individual and cultural differences. All clients must be given equal access to services, information, and programs whether the department or contracted vendors deliver services. The following are summaries of requirements:
1. Interpreters are used when interpreter services are requested by the client; necessary to determine a client's eligibility for services; necessary for the client to access services.
2. LEP and Sensory Impaired (SI) clients are informed of their right to request an interpreter or auxiliary aid and are offered interpreter services or auxiliary aids at no cost to them and without significant delay. Children under age 18 are not allowed to serve as interpreters. LEP Interpreters and Translators for spoken language must be certified and/or qualified by DSHS and comply with the DSHS code of professional conduct.
3. To assure access and quality, DSHS maintains a statewide translation contract, American Sign Language contract telephonic interpreters, written translation, Communication Access Real Time (CART), Telecommunication Relay Services and other auxiliary services, through the Department of Enterprise Services, the Health Care Authority, and the Office of the Deaf and Hard of Hearing.
5. Procedures are in place to obtain translation of official publications, forms and records as well as client specific requests for translations.